Designation of Authorized Personal Representative for Health Information

Montana Department of Public Health and Human Services
P.O. Box 202960, Helena, MT 59620-2960

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gives you the right to have one or more individual(s) act as your Authorized Personal Representative to make decisions regarding the use of and sharing of your Protected Health Information ("PHI"). This form provides that Authorized Personal Representative information to the Department of Public Health and Human Services ("DPHHS"). You can limit the information to be provided to your Authorized Personal Representative and you can cancel this designation at any time.

DESIGNATION SECTION

I, _____, (print your name) hereby name the following person to act as my Authorized Personal Representative with respect to decisions involving the use and/or sharing of my Protected Health Information.

_____
(Print Name of Personal Representative)

INFORMATION LIMITS - Please check one

___ My Personal Representative is to be given all of the privileges that would be given to me with respect to my health information.

___ My Personal Representative is acting on my behalf only for the following functions:

List Functions:

_____

_____

_____

I understand that I may cancel this designation at any time by signing the revocation section of my copy of this form and returning it to the Department of Public Health and Human Services. I understand that any cancellation can only apply to future disclosures or actions regarding my Protected Health Information and cannot cancel actions taken or disclosures made while the designation was in effect.

_____ _____
Signature Date

Revocation of Personal Representative

I no longer want this person to act as my personal representative.

Signature_____Date_____